



Citation for published version:

Butler, CA 2009, 'Sexual and gender minority therapy and systemic practice', Journal of Family Therapy, vol. 31, no. 4, pp. 338-358. <https://doi.org/10.1111/j.1467-6427.2009.00472.x>

DOI:

[10.1111/j.1467-6427.2009.00472.x](https://doi.org/10.1111/j.1467-6427.2009.00472.x)

Publication date:

2009

Document Version

Peer reviewed version

[Link to publication](https://doi.org/10.1111/j.1467-6427.2009.00472.x)

University of Bath

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Abstract

Sexual and gender minority therapy and systemic practice

While there has been an increase in papers addressing working with lesbian and gay clients over the last two decades, this paper builds on this historical context to combine the latest developments in therapy with sexual and gender minority clients with principles of systemic theory and practice. Clear guidelines are provided on how to apply sexual and gender minority therapy within a systemic frame. Specific issues relating to sexual and gender minority couple and family work are addressed, with the provision of further suggestions and resources.

Suggested running head: SGMT and systemic practice

Sexual and gender minority therapy and systemic practice

Sexual and gender minority therapy (SGMT) relates to the approach taken by therapists irrespective of their therapeutic modality. It is not an additional skill set but is used within existing therapy methods, in this case, within systemic practice. In the past SGMT has been referred to as 'Gay Affirmative Therapy' or 'Sexuality Affirmative Therapy'. This paper will consider how systemic practice provides an empowering and respectful way of working with clients from sexual (lesbian, gay and bisexual) and gender (transgender/transsexual) minorities.

When working with these minority communities, it is important to remain mindful that the client's sexuality or gender may not be the issue that they bring to explore in the therapy. There is a balance between under and over-emphasising the relevance of this aspect of a client's presentation. So while the context of being in a sexual or gender minority (SGM) will be important to consider during the conversation (e.g. not using the term 'girlfriend' or 'boyfriend' but 'partner' instead), the concerns the client brings to therapy may not be directly related to this. SGM clients will obviously also deal with many of the same difficulties and dilemmas as heterosexual clients, such as balancing distance and closeness/autonomy and intimacy in relationships (Bernstein, 2000).

The co-construction of the focus of the work in systemic therapy allows for the exploration and discussion of the highest context influencing the current dilemma. The complexity of our clients' lives and the multiple parts of their identities will interact in

sometimes unpredicted ways, so an awareness of SGM issues is important for any therapist working with this client group. Of concern is that the majority of systemic therapists receive relatively little training on how to work with SGM clients (Malley & Tasker, 2004). Murphy *et al.* (2002) confirm that most therapists do not learn about SGM issues through their training course, but instead through reading and continued professional development. However, Garnets *et al.* (1991) estimate that 99% of therapists will see at least one SGM client during their career, although they may not realise this if they assume the client is heterosexual and the client does not disclose (Ussher, 1991). Fortunately, there is a growing body of literature that explores SGM issues. To this end, this paper will start by considering the historical perspective of SGM within a therapy context.

Historical context

Homosexuality was considered a mental illness by the American Psychological Association (in the Diagnostic Statistic Manual) until 1973 and by the World Health Organisation until 1992 (in the International Statistical Classification of Mental and Behavioural Disorders). Prior to this time, lesbians and gay men could receive ‘treatment’ on the NHS, which included barbaric practices such as hormone treatment or, at the extreme, lobotomy (Kutchins & Kurk, 1999). Sadly, respectful and equal treatment in mental health and other NHS services did not follow the declassification of homosexuality as a mental illness. McFarlane (1998), King *et al.* (2003), among others, have provided a wealth of evidence that SGM people are still dissatisfied with their treatment in mental health services, in which they can experience prejudice, discrimination and overt homo- and trans-phobia. Transsexual people still receive

‘treatment’ within the paradigm of psychiatric classification if they meet the criteria for Gender Identity Disorder (Di Ceglie, 2000).

While therapy aimed at changing someone’s sexual orientation (often referred to as ‘conversion’, ‘reorientation’ or ‘reparative’ therapy) has not been offered on the British NHS since the 1973 declassification, such therapy is available in the private sector. This ‘therapy’ is frequently funded and supported by right-wing Christian movements (Shidlo *et al.*, 2002). For example, the National Association for the Research and Treatment of Homosexuality (NARTH) in the US offers ‘evidence’ and ‘treatment’ in line with this approach (Nicolosi, 1993). Fortunately, the American Psychology Association (1998) released a statement that there is no sustainable scientific evidence for the effectiveness of reparative therapy, and that changing sexual orientation should never be a goal of therapeutic treatment.

Emerging from this historical context, the Goods and Services Act (Sexual Orientation) (2007) now makes it an offence to discriminate against people when providing a service because of their sexuality. The last few decades have seen parallel developments in both practice and writing about appropriate and meaningful therapy for SGM people. Alan Malyon first used the term ‘gay affirmative therapy’ (GAT) in 1982: ‘Gay affirmative psychotherapy is not an independent system of psychotherapy. Rather, it represents a special range of psychological knowledge which challenges the traditional view that homosexual desire and fixed homosexual orientations are pathological’ (p. 68). Since then, GAT has been developed and guidelines devised by a

variety of authors (e.g. Clark, 1987; Davies, 1996; Kort, 2008; Ritter & Terndrup, 2002).

However, there have also been critics of the term 'GAT'. The use of the word 'gay' excludes lesbians, bisexuals, transsexuals, or anyone else who may receive mistreatment because of their choice of sexual practices, e.g. members of the 'kink' sadomasochistic community (Simon & Whitfield, 2005). Because of this critique, this approach has sometimes been called 'Sexuality Affirmative Therapy', although this still excludes transsexuals. It has also been questioned what is being affirmed, both in terms of whether identity is regarded as fixed or ever-changing, and in terms of whether behaviour is necessarily useful and positive for the client. In addition, does the therapist have the authority to recognise and validate a client's experience (Simon & Whitfield, 2005), particularly if it is very different from their own? Because of these critiques, Davies is now using the term Sexual and Gender Minority Therapy (*personal communication*).

SGMT and systemic practice

As previously stated, there are various principles and guidelines proposed for SGMT. In this section, the principles and practice that fit with systemic theory will be presented. The following can therefore be taken as systemic SGMT guidelines.

Understanding and challenging the context of heterosexism

Firstly, it is worth noting the meaning of the shift from the term 'homophobia' to 'heterosexism' and 'sexual prejudice'. 'Homophobia' was first coined by Weinberg

(1972) as a fear, hatred or disgust about attraction or love for members of one's own sex and of those feelings in others. However, this term has been challenged as individualising a socio-culturally reinforced position, as such an attitude is not a 'phobia' but a social construction that is acted upon in hate crimes. Individualising it depoliticises it and removes collective responsibility (Herek, 2004; Kitsinger, 1997). Alternatives that have been suggested include being 'homo-negative', 'homo-prejudiced', 'homo-ignorant' (Morrow, 2000) or displaying 'homo-avoidance' (with the idea of 'don't ask, don't tell') (Kort, 2008). However, these alternatives also make this an individual attribute. A workable alternative that identifies the socio-cultural reinforcement and dominant discourse is 'heterosexism', and more recently the term 'sexual prejudice'. Herek defines heterosexism as a 'cultural ideology that perpetuates sexual stigma by denying and denigrating any non-heterosexual forms of behavior [*sic*], identity, relationship, or community' (2004; p. 16), and sexual prejudice as 'negative attitudes based on sexual orientation, whether the target is homosexual, bisexual, or heterosexual' (2004; p. 16). However, these terms do not capture the experiences of discrimination of trans people, and the common term for this is 'transphobia' – which again falls into the trap of locating this as an individual issue, rather than prejudice and violence against people who do not fit the dominant expected gender norms. In this paper this will be referred to as 'anti-trans'. Everyone is raised and lives within heterosexist and anti-trans culture – this has been highlighted in exercises such as 'Homoworld' (Butler, 2004), which requires participants to consider the pervasiveness and subtlety of heterosexual-normalising messages that are received multiple times a day (e.g. in advertising, radio songs, office talk, etc).

Therapist self-reflectivity

Self-reflectivity is central to systemic practice and supervision; Roberts (2005) asserts that this is ‘crucial’ when it comes to ‘identities that have been marginalised or discriminated against, or identities that carry privilege’ (p. 46). Therapists working with SGM clients need to have explored and be aware of their own sexuality and have considered how this might influence their work with clients. This is pertinent both to SGM therapists, to check against assumptions of knowledge or shared meaning based on similarity, and for heterosexual and/or non-trans therapists, to be able to work ‘cross-culturally’ in much the same way as working across, race, religion, gender, etc.

Because of the subtlety and pervasiveness of heterosexism, it is important for heterosexual therapists to have considered their own heterosexual privilege (Bernstein, 2000), such as not having to think twice before using their partner’s name when in conversation with others, or describing what one did at the weekend. In addition, an in-depth examination of the therapist’s beliefs, attitudes and feelings about SGM people and socio-cultural practices is required. A recent panel of experts on LGB therapy issues voted this self-exploration as essential and ongoing (Godfrey *et al.*, 2006). Interestingly, the other main criteria they voted as essential was maintaining a systemic perspective (whether the therapist’s orientation was systemic or of another modality).

A useful tool for this self-reflection is the Coordinated Management of Meaning (e.g. Hannah, 1994) to consider the different stories about sexual and gender minorities that a therapist has come across – from their culture, their family, in relationships with others and within their own identity. Some of these stories will enable conversations

with clients, others will be limiting. To work on those stories that are limiting, a therapist may take these issues to their own personal therapy or supervision. Noticing how comfortable one feels raising these issues in either setting is in itself telling and may provide the starting block to explore further.

Locating your position, transparency and self-disclosure

Self-disclosure is practiced by systemic therapists as a method of locating the therapist's position on what is discussed, and so being transparent with the client about where their statements or questions come from. Feminist therapists (e.g. Brown, 1994; Mahalik *et al.*, 2000) have purported that self-disclosure increases collaboration between the therapist and client(s) and affirms shared experiences, demystifies the process of therapy and acknowledges differences in power in the relationship and so decreases hierarchy. Disclosure of sexual orientation has been cited (e.g. Milton *et al.*, 2002) as important when working with SGM clients, as it assists engagement and allows for a discussion of similarity and difference in relation to power, knowledge and how opinions are formed. Self-disclosure has also been used as a tool by reflecting team members (Anderson, 1987, 1990) sharing personal stories relevant to the family's dilemma, or in narrative therapy when team members may ask questions of each other in front of a family to locate their position (White, 1997). Malley and Tasker (1999) suggest a team of therapists of different sexualities could be a useful resource in some situations.

However, Roberts (2005) asserts that self-disclosure can be 'both helpful and hazardous simultaneously' (p. 50). For example, she suggests that when working with

couples or families, the therapist could find that some members of the system find the disclosure useful, while others may experience it as a violation of boundaries, or as an alliance formation with some members of the system at the exclusion of others. For example, a lesbian therapist might be viewed by a heterosexual spouse as allied to her recently 'outed' husband, or a heterosexual therapist might be considered allied to the parents of a lesbian or gay youth. Roberts suggests some guidelines to take into account when considering self-disclosure that negotiate the more powerful position of the therapist:

- At the start of therapy, invite clients to ask you questions they feel are relevant, such as what informs your approach to therapy: this includes your sexual orientation now and in the past. This will allow clients to make an informed choice about whether they want to work with you.
- Disclose a small amount at a time, always moving the conversation back to the client's presenting concerns. This allows the client to ask more if they feel it would be helpful. Within this, the therapist can decide their own boundary beyond which they do not wish to disclose, for example they may disclose that they are gay but might not disclose that they are in a non-monogamous relationship if not thought useful or relevant.
- The therapist should monitor their own emotional responses during and after a disclosure as a guide to when to give less information if not emotionally processed, and to keep focused on the client's agenda.
- Disclosures should be made to encourage multiple perspectives, and so the therapist should be open to a variety of potential responses from the client following their disclosure.

- Disclosures should be made to share dilemmas and add to an ongoing conversation and not to provide solutions. Ideally a disclosure may add new information or shift a client's perspective on an issue.
- The system and place of one's work will impact on the therapist's ease and support in making personal disclosures. For example, a therapist may feel more comfortable disclosing their SGM position in private practice than if working in a school environment (Harry, 1993).

The client as the expert, the therapist as curious

Taking Anderson and Goolishian's (1992) 'not knowing' approach elicits the local knowledge of the client on SGM issues and their meaning of them. This extends the idea from SGMT that therapists should respect clients' sexuality, lifestyle, culture, choices, attitudes and beliefs around sex, sexuality and gender. It allows the therapist to sit within the domain of exploration (Lang, *et al.*, 1990) and take a curious and non-directive approach to understand the client's construction of their world. However, there is an important difference between taking a not-knowing stance of curiosity to refine and fine-tune a client's meanings and understandings, to the therapist just not having any knowledge about SGM issues. Bernstein (2000) reports that clients can resent having to educate their therapist about their life, and so it is the responsibility of the therapist to gain some background general knowledge (e.g. through relevant films, novels, socialising, or via information and campaigning sites such as www.stonewall.org.uk).

Connecting to wider systems and valuing multiple perspectives

Davies (1996) suggests it is important to help clients develop positive networks; this can help clients who have been exposed to multiple negative messages about being an SGM to be linked to resources that offer alternative positive stories, e.g. through film, books, the internet, etc. This suggestion has been criticised in less directive therapy paradigms (e.g. du Plock, 1997). However, systemic therapy actively explores wider systems and there is a tradition of direct contact with them, for example in recruiting witnesses or therapeutic letter-writing (e.g. White & Epston, 1990). Exploring SGM identities and social networks therefore provides a way to find a range of alternative options for clients to link with, which they might find nurturing and liberating. For example, trying to meet a boyfriend via Gaydar (an internet site often used by gay men to make sexual contact) might be replaced by joining a discussion or reading group. This direct contact with SGM communities can also be extended to the therapist, by getting involved in challenging oppressive practices and campaigning for change (like Madigan and Goldner's (1998) work with the Anti-Anorexia League). For example, a therapist could write a critique of heterosexist articles published in their professional journal, or invite a colleague to account for their limiting conceptualisation of SGM lives by exploring where their ideas come from. Beyond the professional context, a therapist might decide to walk in a Pride march or go to an SGM rally.

There is a growing body of literature that attends to some of the unique and specific issues that arise when working with SGM couples and families. These will now be briefly considered in light of the principles of SGMT described.

Working with SGMT couples

The context of being an SGM couple will 'have different norms and assign different meanings to issues such as sex, monogamy, relationships with extended family, family-of-choice relationships, and the place of the ex-partner in the couple's life' (Bepko & Johnson, 2000; p. 416). Some therapists have proposed models of lesbian (Slater, 1995) and gay (McWhirter & Mattison, 1984) couples as a response to earlier exclusively heterosexual models such as the Family Life Cycle (Carter & McGoldrick, 1980). Carter and McGoldrick (1989) did revise their model to include lesbians, but unfortunately only from the pathologising stance of describing 'lesbian fusion': a concept readily critiqued as having no evidence (Green *et al.*, 1996), and as deprived from a heterosexist stance by comparing same-sex relationships to opposite-sex ones in which gender roles provide individual definition (Malley & Tasker, 1999). Gender roles for SGM couples are thought to have a greater impact on the relationship than sexual orientation *per se* (Kurdek, 1994). Bepko and Johnson (2000) provide an insightful examination of how internalised gender role expectations can limit and suffocate same-sex relationships, where gendered stereotypical beliefs and behaviours are less relevant.

It can therefore be useful to deconstruct gender role expectations in therapy and discuss whether these ideas are useful or limiting to the couple. Therapists will also be influenced by gendered expectations of couple behaviour; for example, they may expect men to be more independent and less emotional than women (e.g. Kort, 2008). Alternatively, they may impose heterosexist gender role divisions on same-sex couples, for example expecting one partner to be 'butch' or take a 'male role', while the other partner is considered 'femme' or the 'female role' (Bernstein, 2000). Gender

role assumptions can be particularly pertinent for trans clients who may have broken expected gender norms in their pasts and so be especially attuned to gendered expectations and their fulfilment of these.

Slater's (1995) model of a lesbian family life cycle proposed five stages:

1. The formation of a couple relationship – noting individual excitement and fears of vulnerability
2. The establishment of an ongoing relationship – negotiating differences and similarities between partners
3. Commitment – with future-planning
4. Generativity – acknowledging the significant contribution to each other's lives, possibility parenting
5. Older couples – negotiating older life changes such as health concerns, grand-parenting, death

McWhirter and Mattison's (1984) model for gay men takes a similar format to the first four stages of Slater's model, being renamed 'blending, nesting, maintaining and building'. However, in their model Stage Five is 'releasing', where the couple becomes more individualised, being able to take the relationship for granted. Stage Six is when the couple then comes back together as a unit: 'renewing'.

Unfortunately, these alternate models still take a normalising stance in privileging long-term, monogamous, co-habiting relationships – thus ignoring the flexibility of many SGM relationships (Weeks *et al.*, 2001). The complexities of bisexual and trans relationships are also not considered. For example, a bisexual person may struggle

with disclosing their sexuality to their partner, who might assume they are heterosexual or lesbian/gay (Goestouwers, 2006). In an opposite-sex relationship a bisexual person may feel a lack of validation of their non-heterosexual identity, and the couple may need to negotiate how these desires and attraction are managed, e.g. though polyamory (Bradford, 2006). For a person who has transitioned from one gender to the other, their relationship in theory shifts from a lesbian/gay to heterosexual one, or vice versa. Similarly, their partner's identity could in theory shift from lesbian/gay to heterosexual or vice versa. However, couples or partners may be unhappy with this shift in semantics when their relationship and partner's identity may not have changed (Embaye, 2006). If a member of a heterosexual married couple transitions and changes their gender on their birth certificate (as permitted by the Gender Recognition Act, 2004), their marriage is no longer valid as they are now the same gender.

All these afore-mentioned 'life cycle' models give no consideration to the socio-cultural context of members of the couple – particularly pertinent in SGM relationships where there is more mixing of religion, ethnicity, age and class than in heterosexual couples (Kitzinger & Coyle, 1995). Bepko and Johnson (2000) suggest this is because of the smaller 'pool' of partners to choose from, but warn that being in a SGM relationship does not negate the power imbalances these differences will bring.

These factors, amongst others, will have a bearing on how comfortable each member of the couple is in disclosing their sexuality or gender variance to friends and family. This may result in the members of a couple being at different stages of being 'out':

with one person being comfortable in their sexual identity with themselves and friends/family and perhaps having more sexual experience, while the other is still struggling with these issues. Therapists working with such couples do well to take the position of multiple perspectives and highlight all the strengths both partners bring to the relationship in the context of their developing sexuality together.

Since 5th December 2005, same-sex partnerships have been able to be legally registered under the Civil Partnership Act. This is the second piece of legislation (following the revised Adoption & Children Act, 2002) to redress the legal inequalities between heterosexual and same-sex couples. However, this union is not recognised internationally and a religious ceremony is not allowed. While some same-sex couples have embraced the chance to register their commitment to each other, others criticise this option as aping heterosexuality, privileging long-term committed couples (e.g. Barker, 2006), and it does not encompass the diversity and richness of sexual minority relationships.

People may be together as a heterosexual couple when one member comes out as having a developing SGM identity. Buxton (2006) suggests that after such a disclosure couples are equally likely to split up immediately, stay together for 2 or 3 years to try to compromise but then eventually split up, or redefine their relationship so they can stay together. Initially, a heterosexual or non-trans partner may feel a range of emotions after disclosure, including feeling cheated, embarrassed, fooled, worried about being judged by others and not knowing how to move forward as a couple (Kort, 2008). Alternatively they may feel relief, having known something was wrong in their

relationship and now understanding why. Heterosexual wives have been reported to feel guilt and self-blame that they have failed in their duties as a wife and somehow caused their husband's homosexuality (Gochros, 1985); while heterosexual husbands have been reported by their lesbian ex-wives, (as these men do not come forward as research participants), as developing long-term animosity and occasionally physical abuse (Hanscombe & Forster, 1982). The Straight Spouse Network, while American, can be a useful resource for clients (www.ssnetwk.org), as can literature such as A.P. Buxton (2006). *The Other Side of the Closet: The Coming-Out Crisis for Straight Spouses*. New York: John Wiley & Sons.

Working with SGM families

An SGM child

Children may be aware of same-sex sexual attraction or feeling different about their assigned gender from a young age, but the labels of LGB or T are unlikely to be used for self-identity until adolescence (Remafedi *et al.*, 1991). There are various models of 'coming out' for the individual that are beyond the scope or focus of this paper (for examples see Cass, 1979; Coleman, 1982; D'Augelli, 1994; Rivers, 1997 or Woodman & Lenna, 1980). However, what is of relevance is the systemic impact that the public declaration of being from an SGM has on the child's family, as it is the anticipation of this and the family's actual response that has been found to significantly impact upon an adolescent's self-awareness and acceptance of their sexual identity (Tasker & McCann, 1999). It is important to note the risk issues for the child associated with negotiating these tasks, with increased risk of self-harm, suicide, anxiety, depression, substance abuse, school refusal or running away from home (Remafedi *et al.*, 1991;

Rothblum, 1990; Rotheram-Borus *et al.*, 1994). These responses may be the result of family rejection, violence or being thrown out of home (Green, 2000). SGM children of whatever age will be able to predict how their family will receive the news based on ‘specific knowledge of their parents’ attitudes toward sexuality in general, homosexuality in particular, and the normative attitudes towards lesbians/gays in the parents’ sociocultural niches (as defined by the intersection of ethnicity, race, social class, religion, and political attitudes)’ (Green, 2000; p. 262). Children at any age are most likely to come out to a family to whom they feel emotionally close, where there is open communication and little conflict (Green, 2000).

DeVine (1984) has suggested a stage-theory of coming out for the family itself:

- *Subliminal awareness* – the child’s sexuality is suspected, provoked by noticing behaviours such as avoiding certain topics in conversation, no heterosexual dating or certain friendship choices
- *Impact* – these suspicions are confirmed and the child declares their sexuality
- *Adjustment* – the family grapples with maintaining homeostasis and the child is pressured to change or hide their sexuality
- *Resolution* – the family discards their heterosexual image of the child and adopts a new SGM identity
- *Integration* – the family shifts their values and ideas about homosexuality or transgender

Strommen (1990) highlights the magnitude of the shifts in thinking that are needed by family members in order to resist negative stereotypes of SGM people, mourn the loss of the heterosexual or gendered identity attached to their child (with ascribed

milestones such as weddings and children) and move to a position where their child's newly-disclosed sexuality or gender identity are viewed as just one part of their identity alongside the familiar other aspects.

However, as with all stage models, this does not take account of important differences between families. For example, families with strong religious views may find adjustment to the news of an SGM child more difficult to accept (Collins & Zimmerman, 1983), as do families with poor methods and resources to respond to a 'crisis' (DeVine, 1984). Families with strong 'rules' about gender norms are likely to react negatively (MacDonald & Games, 1974), and family members will respond more negatively to homosexuality in the same gender as themselves (i.e. a father will struggle more with a gay son than with a lesbian daughter) (Herek, 1984). Finally, the different ages of family members will effect how they react to the disclosure, with young children and older adults responding better than adolescents and adults (Bozett, 1987; Clayton, 1982). Strommen (1990) suggests this is perhaps because those younger and older are less affected by social stigma.

Disclosure can happen because the child feels anxious or guilty about having to hide a part of themselves and their life from their family (Coleman, 1982). However, the child also risks loss of support, distress and at worst potential abuse and violence (Hersch, 1991). Disclosure could also intensify existing family problems (Kort, 2008). The family might respond by not taking the disclosure seriously and seeing it as just a 'phase', denying the existence of the child's partner or blaming the partner for 'corrupting' the child into being an SGM (Kort, 2008). Even accepting parents may

react to the news with feelings of having failed, or guilt that their child's sexuality or gender identity is 'their fault' (Strommen, 1990).

Green (2000) suggests that the role of therapists in situations of disclosure to the family is to explore the advantages and disadvantages of coming out without any preconceived ideas of which path should be taken. Therapists should resist applying principles extrapolated from work with heterosexual clients that privilege revealing family secrets and the necessity of family-of-origin closeness for individual well-being, when actually research with adult SGM people indicates that friendship support is more influential than family-of-origin support (Green, 2000).

If a child does decide to come out it can be useful to link families and the child to resources and support networks so they do not feel alone and can share their experiences. This is echoed by Stone Fish and Harvey (2005), who emphasise the need to promote identification with others in the similar situation of having moved from a family of heterosexuals to one of multiple sexual identities. This is particularly important given that research indicates that schools do very little to support SGM young people or challenge prejudice (Adams *et al.*, 2004; Ray & Gregory, 2001). Organisations such as PFLAG (Parents, Friends and Family of Lesbians and Gays) or Gender Identity Research and Education Society (GIRES at www.gires.org.uk) provide such a service.

PFLAG interviewed their members and identified four stages of adjustment for parents (Griffin *et al.*, 1986), all of which can be worked through in therapy:

Finding out – Therapists can assist family members to reflect on the range of their emotional reactions, and establish rules of how to discuss this with their child. At this early stage the family may deny the child's identity shift or request the therapist's help with a conversation attempt. It is important for the therapist to not collude with any bargaining and gently challenge any denial. Providing some factual information may also be appropriate at this point, along with bibliotherapy.

Communicating with others – If the news spreads beyond the family, the therapist can help family members rehearse how to discuss this. At this point it may be useful for family members to link up with organisations such as PFLAG to receive support from other parents and to overcome any feelings of fear, loss or blame.

Changing inner perceptions – At this point parents can be helped to grieve the loss of a heterosexual child and the expectations connected to this, and more information-giving may be necessary (e.g. that they could still become grandparents). Parents can be helped to recognise heterosexism in society and the effects of this on their children and themselves.

Taking a stand – The therapist can assist parents to 'come out', confront homophobia, speak out in public and educate critics. Forming allies with other parents may be useful. The therapist can help parents develop alternative visions of the future and narrative consistency with the past.

Some useful books for SGM children and their parents are:

M.V. Borhek (1993). *Coming out to parents: a two-way survival guide for lesbians and gay men and their parents*. Cleveland: Pilgrim

L. Stone Fish & R.G. Harvey (2005). *Nurturing queer youth: family therapy transformed*. London: Norton

Cohen-Kettenis P.T. & Pffafli F. (2003). *Transgenderism and intersexuality in childhood and adolescence: making choices*. London: Sage

Or the website for trans youth: www.mermaids.freeuk.com

An SGM parent

Ariel and McPherson (2000) explain that there are two routes to becoming an SGM parent. The first and more common route (Ritter & Terndrup, 2002) is from a previous heterosexual relationship or prior to transitioning; the second is when adults who already identify as an SGM have a child. Bisexuals who find themselves in a long-term same-sex relationship may have to grapple with fears that they may not have children as they give up the seeming straightforwardness of having children with a partner of the opposite sex. The various routes to becoming a parent via this second route include insemination and surrogacy, fostering and adoption, and becoming a step-parent through a new relationship with an existing parent. It is beyond the scope of this paper to go into these options in detail, but McCann and Delmonte (2005), as well as Tasker and Patterson (2007), provide useful overviews of the processes and psychological considerations of these various options. Similarly, Weeks *et al.* (2001), Ariel and McPherson (2000), and Tasker and Bigner (2008) explore the networks of care-giving within families of lesbians and gay men – sometimes referred to as ‘families of choice’ (Weston, 1991). It is important that therapists ask clients about how they define their ‘family’, as it is likely to move beyond heterosexual definitions focused on biological kinship (Perlesz *et al.*, 2006).

It has been estimated that about one in five lesbians and about one in ten gay men are parents (Bryant & Demian, 1994). Most research in this area is with lesbian mothers; more research is needed with gay fathers and transsexuals. There are many social myths around SGM families, including that children will grow up to be SGM themselves, that children will be socially maladapted, that the families will not stay together, etc. It is beyond the scope of this paper to present all the research that debunks these prejudiced myths, but useful summaries are provided by McCann and Delmonte (2005), Ariel and McPherson (2000) and Tasker and Patterson (2007). Ultimately, the most significant impact on child development comes from the quality of the parenting and commitment of those involved, and not the gender or sexuality of the parents (McCann & Delmonte, 2005).

The influence of heterosexism and prejudice on all members of the family will have various effects of SGM parents in numerous ways. Parental 'culture' (e.g. sports days, school plays, school gate gossip, etc) is strongly heterosexual (Ritter & Terndrup, 2002). SGM parents have to negotiate this, either by being out or hiding their sexuality – both strategies risk the loss of support of other parents. In addition, if the parents decide not to come out, the whole family has to maintain an 'illusion of heterosexuality' (Baptiste, 1987; p. 128) that can be an ongoing stress. However, there are times when SGM parents want support from other heterosexual parents and their SGM childless friends may not understand the parenting concerns they are struggling with.

The decision to disclose to children is important, whether a parent is ‘coming out’ from a heterosexual context such as marriage, or whether an established SGM parent is answering a child’s questions of ‘where did I come from?’ (this may be easier for couples where both birth parents are still involved). Similarly, parents might be concerned about disclosing to a child their transsexual feelings and potential future transitioning. Any disclosure needs to be well-timed and age-appropriate. Perrin and Kulkin (1996) suggest that pre-school children can understand the concept of various forms of loving relationships and a co-constructed definition of ‘family’ can be arrived at. When children enter school they may need to be taught the idea of ‘differential disclosure’ – of telling people they think are fine with the news, but not telling others. Children will become more aware of the dangers of being teased or bullied because of their parent’s sexuality or trans status as they get older (Ray & Gregory, 2001) and they may need help managing the potential burden of secrecy and disclosure to minimise any harassment or stigmatisation (Gold *et al.*, 1994). Parents may also worry that their child will be bullied because of this – perhaps a warranted fear given that one study reported that half of children from lesbian and gay parents had been bullied due to their parents’ sexuality (Ray & Gregory, 2001). However, other studies have found that children of SGM parents are no more likely to be bullied than their peers (Tasker & Patterson, 2007). Adolescents privilege conformity with their peers, and are themselves developing their own sexuality at this time, and so may struggle with their parent’s sexuality or trans status at this age, even if they had previously accepted it (Gold *et al.*, 1994). Adolescents may be embarrassed to bring friends or dates home, and respond to parents with anger or embarrassment. However, adolescence is in itself a trying time as children struggle to develop their autonomy and so it is important to

separate out issues directly to do with sexuality from those of adolescence in general (Ahmann, 1999).

Ritter and Terndrup (2002) advise parents to come to terms with their own gender identity or sexuality before disclosing to children. They suggest the conversation should be positive and sincere and not apologetic, and that children may need reassurance that loving relationships with parents will not change. They also suggest practicing answers to questions that children might ask, such as ‘What does being LGB or T mean?’, ‘What makes a person LGB or T?’, ‘Will I be LGB or T too?’ or ‘What should I tell my friends?’. Parents should be prepared that the complexities of disclosure multiply when they involve family relationships and not just the disclosure of an individual (Tasker & Patterson, 2007). Tasker and Patterson (2007) provide a useful exploration of this in a school context.

Support exists for children via the internet, e.g. Children of Lesbians and Gays Everywhere (www.colage.org), an American site that supports and connects children where at least one of their parents is LGB or T. There may also be local LGBT parent groups, which could be identified via the local Lesbian and Gay Switchboard. In addition, ‘Depend’ offers support to all family members of transsexuals (www.depend.org.uk).

Conclusion

As stated at the start of this paper, issues of sexual and gender identity may not always be the focus of the work conducted with SGM clients. However, aspects of this

identity will have a bearing on presenting problems, for example, when identifying a client's support network. In addition, there are specific issues that relate to lesbian and gay couples and families that may be the focus of the work. Such issues have been discussed in detail in this article, and competence in practice will be developed by applying the systemic principles outlined, coupled with further reading and accessing resources, and the continued conversations we have with our clients, colleagues and supervisors.

References

Adams, N., Cox, T. & Dunstan, L. (2004). "I am the hate that dare not speak its name": Dealing with homophobia in secondary schools. *Educational Psychology in Practice*, **20** (3), 259-269

Ahmann, E. (1999). Working with families having parents who are gay or lesbian. *Paediatric Nursing*, **25** (5), 531-535

American Psychiatric Association (1998). "*Reparative therapy*" [Position statement]. Washington DC: APA

American Psychiatric Association (1973). *Diagnostic and Statistical Manual of Mental Disorders – III*. Washington: APA

Anderson, T. (1987). The reflecting team: dialogue and meta-dialogue in clinical work. *Family Process*, **26**, 415-428

Anderson, T. (Ed.). (1990). *The reflecting team: dialogues and dialogues about the dialogues*. Kent, UK: Borgmann

Anderson, H. & Goolishian, H. (1992). The client is the expert: a not-knowing approach to therapy. In S. McNamee & K. Gergen (Eds.), *Therapy as social construction*. (pp. 25-39). London: Sage

Ariel, J. & McPherson, D.W. (2000). Therapy with lesbian and gay parents and their children. *Journal of Marital and Family Therapy*, **26** (4), 421-432

Baptiste, A.D. (1987). The gay and lesbian step-parent family. In F. W. Bozett (Ed.), *Gay and lesbian parents*. (pp. 112-137). New York: Praeger

Barker, M. (2006). Why I study ... bisexuality and beyond. *The Psychologist*, **19**, 33-34

Bepko, C. & Johnson, T. (2000). Gay and lesbian couples in therapy: perspectives for the contemporary family therapist. *Journal of Marital and Family Therapy*, **26** (4), 409-419

Bernstein, A.C. (2000). Straight therapists working with lesbians and gays in family therapy. *Journal of Marital and Family Therapy*, **26** (4), 443-454

Borhek, M.V. (1993). *Coming out to parents: a two-way survival guide for lesbians and gay men and their parents*. Cleveland: Pilgrim

Bozett, F.W. (1987). Children of gay fathers. In F.W. Bozett (Ed.) *Gay and lesbian parents*. (pp. 39-57). New York: Praeger

Bradford, M. (2006). Affirmative psychotherapy with bisexual women. In R. Fox (Ed.) *Affirmative Psychotherapy with bisexual women and bisexual men*. (pp. 14-25). Binghampton, NY: Harrington Park Press

Brown, L.S. (1994). *Subversive dialogues: Theory in feminist therapy*. New York: Basic Books

Bryant, S.A. & Demian (1994). Relationship characteristics of American gay and lesbian couples: findings from a national survey. *Journal of Gay & Lesbian Social Service*, **1**, 101-117

Butler, C. (2004). An awareness-raising tool addressing lesbian and gay lives. *Clinical Psychology Forum*, **36**, 15-17

Buxton, A.P. (2006). *The other side of the closet: The coming out crisis for straight spouses and families*. New York: John Wiley & Sons

Carter, B. & McGoldrick, M. (1980). *The Family Life Cycle: a framework for family therapy*. New York: Gardner Press

Carter, B. & McGoldrick, M. (1989). *The Changing Family Life Cycle: a framework for family therapy*. New York: Allyn & Bacon

Cass, V.C. (1979). Homosexual identity formation: a theoretical model. *Journal of homosexuality*, **9**, 105-126

Clark, D. (1987). *The New Loving Someone Gay*. Berkeley: Celestial Arts

Clayton, V. (1982). Wisdom and intelligence: the nature and function of knowledge in the later years. *International journal of aging and human development*, **15**, 315-321

Coleman, E. (1982). Developmental stages of the coming out process. *Journal of Homosexuality*, **7**, 31-43

Collins, L. & Zimmerman, N. (1983). Homosexual and bisexual issues. In J.C. Hasen, J.D. Woody & R.H. Woody (Eds.) *Sexual issues in family therapy*. (pp. 82-100). Rockville, MD: Aspen Publications

D'Augelli, A.R. (1994). Identity development and sexual orientation: toward a model of lesbian, gay and bisexual development. In E.J. Trickett, R.J. Watts and D. Birman

(Eds.), *Human Diversity: Perspective on people in context*. (pp. 312-333). San Francisco: Jossey-Bass

Davies, D. (1996). Towards a model of gay affirmative therapy. In D. Davies and C. Neal (Eds.) *Pink Therapy: A Guide for Counsellors and Therapists Working with Lesbian, Gay and Bisexual Clients*. (pp. 24-40). Buckingham: Open University Press

DeVine, J. L. (1984). A systemic inspection of affectional preference orientation and the family of origin. *Journal of social work and human sexuality*, **2**, 9-17

Di Ceglie, D. (2000). Gender Identity Disorder in young people. *Advances in psychiatric treatment*, **6**, 458-466

du Plock, S. (1997). Sexual misconceptions: a critique of gay affirmative therapy and some thoughts on an existential-phenomenological theory of sexual orientation. *Journal of the society for Existential Analysis*, **8** (2), 56-71

Embaye, N. (2006). Affirmative psychotherapy with bisexual transexuals. In R. Fox (Ed.) *Affirmative Psychotherapy with bisexual women and bisexual men*. (pp. 52-63). Binghamton, NY: Harrington Park Press

Garnets, L., Hancock, K.A., Cochran, S.D., Goodchilds, J. & Peplau, L.A. (1991). Issues in psychotherapy with lesbians and gay men: a survey of psychologists. *American Psychologist*, **46**, 964-972

Gochros, J. S. (1985). Wives' reactions to learning that their husbands are bisexual.

Homosexuality, **11** (1/2), 101-113

Godfrey, K., Haddock, S.A., Fisher, A. & Lund, L. (2006). Essential components of curricula for preparing therapists to work effectively with lesbian, gay and bisexual clients: a delphi study. *Journal of Marital and Family Therapy*, **32** (4), 491-504

Goestouwers, L. (2006). Affirmative psychotherapy with bisexual men. In R. Fox (Ed.) *Affirmative Psychotherapy with bisexual women and bisexual men*. (pp. 28-49).

Binghampton, NY: Harrington Park Press

Gold, M.A., Perrin, E.C., Futterman, D. & Friedman, S.B. (1994). Children of gay or lesbian parents. *Paediatrics in Review*, **15** (9), 354-358

Green, R.J. (2000). "Lesbians, gay men, and their parents": A critique of LaSala and the prevailing clinical "wisdom". *Family Process*, **39**, 257-266

Green, R.J., Bettinger, M. & Zacks, E. (1996). Are lesbian couples fused and gay male couples disengaged? Questioning gender straight jackets. In J. Laird and R.J. Green (Eds.) *Lesbians and gays in couples and families: a handbook for therapists*. (pp. 185-230). San Francisco: Jossey-Bass

- Griffin, W.C., Wirth, J.M. & Wirth, G.A. (1986). *Beyond acceptance: parents of lesbians and gays talk about their experiences*. Englewood Cliff, NJ: Prentice-Hall
- Hannah, C. (1994). *The context of culture in systemic therapy: an application of CMM*. *Human Systems*, **5**, 69-81
- Hanscombe, G. & Forster, J. (1982). *Rocking the cradle*. Boston: Alyson
- Harry, J. (1993). Being out: a general model. *Journal of Homosexuality*, **26**, 25-39
- Herek, G.M. (1984). Beyond 'homosexuality': a social psychological perspective on attitudes toward lesbians and gay men. *Journal of Homosexuality*, **10** (1/2), 1-21
- Herek, G.M. (2004). Beyond 'homophobia': Thinking about sexual prejudice and stigma in the twenty-first century. *Sexuality Research and Social Policy*, **1** (2), 6-24
- Hersch, P. (1991). Gays and lesbians in therapy: Secret lives. *The Family Therapy Networker*. Jan/Feb, 37-43
- King, M., Mckeown, E., Warner, J., Ramsay, A., Johnson, K., Cort, C., Wright, L., Blizard, R. & Davidson, O. (2003). Mental health and quality of life of gay men and lesbians in England and Wales: controlled, cross-sectional study. *British Journal of Psychiatry*, **183**, 552-558

Kitsinger, C. (1997). Lesbian and gay psychology: a critical analysis. In D. Fox and I. Prilleltensky (Eds.), *Critical psychology: an introduction*. (pp. 202-216). London: Sage

Kitzinger, C. & Coyle, A. (1995). Lesbian and gay couples: speaking of difference. *The Psychologist*, **8**, 64-69

Kort, J. (2008). *Gay affirmative therapy for the straight clinician*. London: Norton

Kurdek, A.L. (1994). The nature and correlates of relationship quality in gay, lesbian and heterosexual co-habiting couples. A test of the Individual Difference, Interdependence and Discrepancy Models. In B. Green & G.M. Herek (Eds.), *Lesbian and gay psychology: theory, research and clinical applications*. (pp 133-155). Thousand Oaks, CA: Sage.

Kutchins, H. & Kirk, S. (1999). *Making us crazy: DSM – the psychiatric bible and the creation of mental disorders*. London: Constable and company

Lang, P., Little, M. & Cronen, V. (1990). The systemic professional. Domains of action and the question of neutrality. *Human Systems*, **1**, 32-47

McFarlane, L. (1998). *Diagnosis: Homophobic. The experiences of lesbians, gay men and bisexuals in mental health services*. London: PACE

- McWhirter, D.P. & Mattison, A.M. (1984). *The male couple: how relationships develop*. Englewood Cliffs, NJ: Prentice-Hall
- MacDonald, A. & Games, R. (1974). Some characteristics of those who hold positive and negative attitudes towards homosexuals. *Journal of Homosexuality*, **1**, 9-27
- Madigan, S.P. & Goldner, E.M. (1998). A narrative approach to anorexia: discourse, reflexivity and questions. In M. Hoyt (Ed.), *Constructive Therapies*. (pp. 380-399). New York: Jossey Bass
- Mahalik, J.R., van Ormer, E.A. & Simi, N.L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M.M. Brabeck (Ed.), *Practicing feminist ethics in psychology*. (pp. 189-202). Washington, DC: American Psychological Association
- Malley, M. & Tasker, F. (1999). Lesbians, gay men and family therapy: a contradiction in terms? *Journal of Family Therapy*, **21** (1), 3-29
- Malley, M. & Tasker, F. (2004). Significant and other: systemic family therapists on lesbians and gay men. *Journal of Family Therapy*, **26**, 193-212
- Maylon, A. (1982). Psychotherapeutic implications or internalized homophobia in gay men. *Journal of Homosexuality*, **7** (2/3), 59-69

McCann, D. & Delmonte, H. (2005). Lesbian and gay parenting: babes in arms or babes in the woods? *Sexual and Relationship Therapy*, **20** (3), 333-347

Milton, M., Coyle, A. & Legg, C. (2002). Lesbian and gay affirmative psychotherapy: defining the domain. In A. Coyle & C. Kitzinger (Eds.), *Lesbian and gay psychology: New Perspectives*. (pp. 175-197). Oxford: Blackwell

Morrow, S.L. (2000). First do no harm: Therapist issues in psychotherapy with lesbian, gay and bisexual clients. In R.M. Perez, K.A. De Bord, & K. Bieschke (Eds.). *Handbook of counseling and psychotherapy with lesbians, gay, and bisexual clients*. (pp. 137-156). Washington, DC: American Psychological Association

Murphy, J.A., Rawlings, E.I. & Howe, S.R. (2002). A survey of clinical psychologists on treating lesbian, gay, and bisexual clients. *Professional psychology: research and practice*, **33**, 183-189

Nicolosi, J. (1993). *Healing Homosexuality: Case studies of Reparative Therapy*. London: Jason Aronson

Perlesz, A. and McNair, R. (2004). Lesbian parenting: insiders' voices. *Australian and New Zealand Journal of Family Therapy*, **25**, 129-140

Perrin, E.C. & Kulkin, H. (1996). Paediatric care for children whose parents are gay or lesbian. *Paediatrics*, **97** (5), 629-635

Ray, V. and Gregory, R. (2001). School experience of the children of lesbian and gay parents. *Family Matters*, **59**, 28-34

Remafedi, G., Farrow, J. A. & Deisher, R.W. (1991). Risk factors for attempted suicide in gays. *Paediatrics*, **87**, 869-875

Ritter, K.Y. & Terndrup, A.I. (2002). *Handbook of Affirmative Psychotherapy with Lesbians and Gay Men*. New York: Guildford Press

Rivers, I. (1997). Lesbian, gay and bisexual development: Theory, research and social issues. *Journal of Community & Applied Social Psychology*, **7**, 329-343

Roberts, J. (2005). Transparency and self-disclosure in Family Therapy: dangers and possibilities. *Family Process*, **44** (1), 45-63

Rothblum, E.D. (1990). Depression among lesbians, an invisible and unresearched phenomena. *Journal of lesbian and gay psychology*, **1**, 67-87

Rotheram-Borus, M.J., Hunter, J. & Rosario, M. (1994). Suicidal behavior and gay-related stress among gay and bisexual male adolescents. *Journal of adolescent research*, **9**, 498-508

Shidlo, A., Schroeder, M. & Drescher, L. (2002). *Sexual conversion therapy: ethical, clinical and research perspectives*. New York: Haworth Medical Press

Simon, G. and Whitfield, G. (2005). *Gay Affirmative Practice and a critical therapy*. Paper presented for panel discussion at the Association of Lesbian, Gay and Bisexual Psychologies Conference, University of Nottingham. Retrieved 05/02/2009 from <http://www.pinkpractice.co.uk/gayaffirm.htm>

Slater, S. (1995). *The lesbian family life cycle*. London: Free Press

Stone Fish, L. & Harvey, R.G. (2005). *Nurturing queer youth: family therapy transformed*. London: Norton

Strommen, E. F. (1990). Hidden branches and growing pains: homosexuality and the family tree. In F.W. Bozett & M. Sussman (Eds.) *Homosexuality and Family Relations*. (pp. 9-34). New York: Haworth Press

Tasker, F. & Bigner, J.J. (2008). *Gay and lesbian parenting: new directions*. New York: Haworth Press

Tasker, F. & McCann, D. (1999). Affirming patterns of adolescent sexual identity: the challenge. *Journal of Family Therapy*, **21**, 30-54

Tasker, F. & Patterson, C.J. (2007). Research on gay and lesbian parenting: retrospect and prospect. *Journal of GLBT Family Studies*, **3** (2/3), 9-34

Ussher, J.M. (1991). Family and couples therapy with gay and lesbian clients: acknowledging that forgotten minority. *Journal of Family Therapy*, **13**, 131-148

Weeks, J., Heaphy, B. & Donovan, C. (2001). *Same sex intimacies: Families of choice and other life experiments*. London: Routledge

Weinberg, G. (1972). *Society and the healthy homosexual*. New York: St Martin's

Weston, K. (1991). *Families we choose*. Boston: Alyson

White, M. (1997). *Narratives of therapists' lives*. Adelaide: Dulwich Centre Publications

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. London: Norton

Woodman, N.J. & Lenna, H.R. (1980). *Counseling with gay men and women*. San Francisco: Jossey-Bass

World Health Organisation (1992). *The International Classification of mental and behavioural Disorders -10*. Geneva: WHO